PRINTED: 12/05/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 4544 1-15-12 OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 445445 12/01/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 PITCOCK LANE CELINA HEALTH AND REHABILITATION CENTER **CELINA, TN 38551** SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 272 483.20(b)(1) COMPREHENSIVE F 272 **ASSESSMENTS** SS=D This Plan of Correction is submitted as required under State and Federal law. Completion The facility must conduct initially and periodically The facility's submission of the Plan of a comprehensive, accurate, standardized Date Correction does not constitute an 12/22/11 reproducible assessment of each resident's admission on the part of the facility functional capacity. that the findings cited are accurate, that A facility must make a comprehensive the findings constitute a deficiency, or that the scope and severity determination assessment of a resident's needs, using the is correct. Because the facility makes no resident assessment instrument (RAI) specified such admissions, the statements made by the State. The assessment must include at least the following: in the Plan of Correction cannot be used Identification and demographic information; against the facility in any subsequent Customary routine: administrative or civil proceeding. Cognitive patterns: Communication; F272 Vision; Mood and behavior patterns; 1. Resident # 18 was scheduled a Psychosocial well-being; Physical functioning and structural problems; dental consult by the Social Continence: Services Director on 12/1/11. Disease diagnosis and health conditions; Resident # 18 was assessed Dental and nutritional status; for pain by the Director of Skin conditions: Nursing on 12/1/11 which the Activity pursuit; Medications: resident denied. The MD and Special treatments and procedures: family were notified on Discharge potential: 12/1/11 by the Director of Documentation of summary information regarding Nursing. the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and All resident dental Documentation of participation in assessment. assessments were reviewed on 12/1/11 by the Director of Nursing and the Social Services Director. No other

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administration

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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CELINA HEALTH AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREF TAG	1: C	PREET ADDRESS, CITY, STATE, ZIP C 20 PITCOCK LANE CELINA, TN 38551  PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	DRRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	by: Based on medical and interview, the comprehensively a resident (#18) of the The findings included Resident #18 was September 27, 20 Severe Anemia, A Mellitus, Hypertens Pulmonary Diseas Review of the Mini October 4, 2011, roout of 15 on the Brindicating the residing the residual than the residing the residual than the residing the residual than the	I record review, observation, facility failed to assess the dental needs for one nirty-one residents reviewed.  Ided:  admitted to the facility on 11, with diagnoses including cute Renal Failure, Diabetes sion, Chronic Obstructive e, and Alzheimer's Dementia.  Imum Data Set (MDS) dated evealed the resident scored 12 ief Interview for Mental Status lent was moderately cognitively ed review of the same MDS, ntal Status revealed, "No oth fragments." (edentulous)  Ising Admission Assessment 127, 2011, Dental Status section per of natural upper teeth; "0" ower teeth. Continued review have any denturesResidenting and cooperating with dental	F	272	residents were ident having been affected.  3. The Interdisciple consisting of the Coordinator, So Director, Licens Staff, Activities Dietary Manage inserviced by the Administrator be 12/1/11 through regarding proper care planning, and of dental services.  4. The Director of audit fifteen den per week for four fifteen charts per two months or uncompliance is acresults will be remonthly by the I Nursing to the Quantity Assurance Performs Improvement concomprised of the Director, Admin Director of Nursing to the University of the	inary Team MDS cial Services ed Nursing Director, and r were eginning 12/13/11 r assessment, ad provision s.  Nursing will tal assessment r weeks then month for ntil 100% hieved. All ported Director of uality rmance mmittee Medical istrator,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		LTIPLE CONSTRUCTION DING	(X3) DATE SI COMPLE	
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	ROVIDER OR SUPPLIER HEALTH AND REHAE	BILITATION CENTER		s	STREET ADDRESS, CITY, STATE, ZIP CODE 120 PITCOCK LANE CELINA, TN 38551		
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F 272	by: Based on medical and interview, the fi comprehensively as resident (#18) of thi The findings include Resident #18 was a September 27, 201 Severe Anemia, Ac Mellitus, Hypertens Pulmonary Disease Review of the Minim October 4, 2011, re out of 15 on the Brid indicating the reside imparied. Continue Section L, Oral/Den natural teeth or toot Review of the Nursi dated September 2 revealed, "0" number number of natural lo revealed "does not capable of acceptin work? Yes" Medical record revie Dietary/Interview/Pr September 28, 201	record review, observation, acility failed to seess the dental needs for one rty-one residents reviewed.  admitted to the facility on 1, with diagnoses including ute Renal Failure, Diabetes ion, Chronic Obstructive, and Alzheimer's Dementia.  Thum Data Set (MDS) dated vealed the resident scored 12 and for the same MDS, tal Status revealed, "No h fragments." (edentulous)  and Admission Assessment 7, 2011, Dental Status section are of natural upper teeth; "0" ower teeth. Continued review have any dentures Resident g and cooperating with dental	F	27	Coordinator, Minimum Coordinator, Social Ser Activities Director, Die Manager, and Housekee Supervisor.	vices, tary	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER HEALTH AND REHA	BILITATION CENTER	3	REET ADDRESS, CITY, STATE, ZIP 120 PITCOCK LANE CELINA, TN 38551	CODE		
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F 281 SS=D	dated November 2 revealed the reside gums hurt through Observation on Derevealed the reside mechanical soft, pure Interview with the Interview with the Interview with the Interview of p.m., confirmed after responsible party, been lost at the hot to wear an old set fit properly, and the to be refitted for not interview confirmed the dental assessment of dentures. 483.20(k)(3)(i) SEF PROFESSIONAL STATE This REQUIREME by:  Based on medical policy, and interview physician orders for one resident (#streviewed.	ident Interview information 8, 2011, at 11:49 a.m., ent confirmed, "sometime out the day"  Identify a meal consisting of bureed meat food items.  Director of Nursing (DON) in an December 1, 2011, at 2:30 the resident's dentures had spital, the resident was unable of dentures because they didn't be family would like the resident was dentures. Continued at the facility had not completed ment to determine the resident's RVICES PROVIDED MEET STANDARDS  ded or arranged by the facility ional standards of quality.  NT is not met as evidenced record review, review of facility we, the facility failed to follow or the treatment of Constipation 50) of thirty-one residents	F 281	1. The Charge Nu clarification or Resident # 50 n bowel protocol The Charge Nu implemented the protocol for thin 11/30/11. The family were no 11/30/11 by the Nursing.  2. All residents in were audited by of Nursing and Coordinator to bowel protocol implemented or	ders for regarding the on 11/30/11. Urse he bowel is resident on MD and otified on e Director of the Staffing insure that the was being n 11/30/11. No were identified	Completion Date 12/22/11	

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	201 - 20102010	LDING	LE CONSTRUCTION	(X3) DATE SI COMPLE	TED	
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PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 281	February 12, 2009 Uncontrolled Diab Reflux, Cerebral \ Hemmorhage, an Minimum Data Se revealed the resid impaired, with a s total of fifteen), or Status.  Medical record re Standing Orders" following prescribe "No BM (Bowel oz (ounces) prune (Milk of Magnesia ounce by mouth); further orders"  Medical record re detail" document documentation the November 10th, 1: protocol had not be review revealed in had a BM on Nove the BM protocol had Continued review resident had a BM 26th, 2011. Conti resident received 2011, but nothing Continued review resident had a BM 2011, and the BM implemented.	9, with diagnoses including betes, Hypertension, Esophageal Vascular Accident, Intracranial and Neuropathy. Review of the et dated September 7, 2011, dent to be severely cognitively score of six (out of a possible in the Brief Interview for Mental	F	281	4. The Director audit fifteen control for four weeks charts per more months or untercompliance is results will be monthly by the Nursing to the Assurance Per Improvement comprised of the Director, Adm Director of Nurset Coordinator, Medical	of Nursing will harts per week then fifteen in the for two il 100% achieved. All reported e Director of Quality rformance committee the Medical hinistrator, ursing, Staffing Minimum Data or, Social vities Director, ger, and		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER HEALTH AND REHAL	BILITATION CENTER	1:	EET ADDRESS, CITY, STATE, ZIP CODE 20 PITCOCK LANE ELINA, TN 38551		
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	a.m., confirmed the constipation in the had not been follow 483.20(k)(3)(ii) SEI PERSONS/PER C.  The services provie must be provided by accordance with eacare.  This REQUIREME by:  Based on medical and interview, the ficare plan for one residents reviewed.  The findings included the f	n December 1, 2011, at 7:50 be bowel protocol for managing Physician's Standing Orders wed. RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in ach resident's written plan of MT is not met as evidenced record review, observation, facility failed to implement the esident (#18) of thirty-one	F 281	1. Resident # 18 was schedental consult by the Services Director on 1 Resident # 18 was assefor pain by the Directon Nursing on 12/1/11 wheresident denied. The Marily were notified on 12/1/11 by the Directon Nursing. Resident #18 plan was updated by the Director of Nursing to current plan of care.  2. All resident care plans reviewed on 12/1/11 by Director of Nursing and Social Services Director insure they accurately reflected plan of care for dental needs. No other residents were identified having been affected.  3. The Interdisciplinary Teonsisting of the MDS	social 2/1/11. essed or of nich the ID and n r of 's care ne reflect were y the d the or to or	Completion Date 12/22/11

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILE	LTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLE	
		445445	B. WING		12/0	1/2011
	SUMMARY ST	ABILITATION CENTER  TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ACTION CROSS-REFERENC	RECTION SHOULD BE	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	FROINAL	
F 282	Identification "Resedentulous" Co "Goal "resident 90 day assessme address dental proconsult as needed Medical record re Dietary/Interview/September 28, 20 edentulous, and have the Review of the Redated November revealed the resignment of the p.m., confirmed the arrangements for 483.55(a) ROUT SERVICES IN SI The facility must routine and 24-hor A facility must processory, in accordant, routine and meet the needs of Medicare resider routine and emernecessary, assis appointments; arto and from the control of the second of the	sident has impaired oral health, intinued review revealed, will have no oral discomfort by nt" Review of approaches to oblems revealed, "dentald"  view of the Prescreen assessment dated 011, revealed the resident was nad chewing problems.  sident Interview information 28, 2011, at 11:49 a.m., dent confirmed, "sometime hout the day"  Director of Nursing in the on December 1, 2011, at 2:30 he facility had not made a dental consult.  INE/EMERGENCY DENTAL	F 28	Coordinator, Social Ser Director, Licensed Nur Activities Director, and Manager were inservice administrator beginning through 12/13/11 regard proper assessment, care and provision of dental  4. The Director of Nur audit fifteen dental assessments per we weeks then fifteen omonth for two month for two month for two months of the Chall Nursing to the Chall Nursing to the Chall	sing Staff, Dietary ed by the g 12/1/11 ding planning, services.  rsing will ek for four charts per ths or until s achieved. eported ector of ity ance nittee edical ator, , Staffing aum Data cial Director, and	

Event ID: QSDD11

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		LE CONSTRUCTION	COMPLE		
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	ROVIDER OR SUPPLIER HEALTH AND REHA	BILITATION CENTER		120	EET ADDRESS, CITY, STATE, ZIP CODE 10 PITCOCK LANE ELINA, TN 38551		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 411	by: Based on medical and interview, the consult for one respectively. The findings included residents reviewed. The findings included resident #18 was september 27, 20 severe Anemia, A Mellitus, Hyperten Pulmonary Disease. Review of the Min October 4, 2011, out of 15 on the Bindicating the resident impaired. Continuation Section L, Oral/Denatural teeth or to Review of the Nurdocumentation dad Dental Status, revupper teeth; "0" in Continued review dentures"and "Fand cooperating with Medical record redical policy interview/ September 28, 20	I record review, observation, facility failed to provide a dental sident (#18) of thirty-one d.  ded:  admitted to the facility on 11, with diagnoses including acute Renal Failure, Diabetes sion, Chronic Obstructive se, and Alzheimer's Dementia.  imum Data Set (MDS) dated revealed the resident scored 12 rief Interview for Mental Status dent was moderately cognitively and review of the same MDS, ental Status revealed, "No oth fragments." (edentulous)  resing Admission Assessment ated September 27, 2011, realed, "0" number of natural number of natural lower teeth. revealed "does not have any Resident capable of accepting with dental work? Yes"	F	411F	1. Resident # 18 was soldental consult by the Services Director on Resident # 18 was ass for pain by the Direct Nursing on 12/1/11 wresident denied. The family were notified a 12/1/11 by the Direct Nursing.  2. All resident dental assessments were rev 12/1/11 by the Direct Nursing and the Social Services Director. No residents were identification having been affected.  3. The Interdisciplinary consisting of the MDS Coordinator, Social Services Director, Licensed Nursing Activities Director, Licensed Nursing Manager were inserviced by the administrator beginning.	Social 12/1/11. sessed for of which the MD and on or of siewed on or of al other fied as Team S ervices arsing etor, and e	Completion Date 12/22/11

Facility ID: TN1401

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPI	LE CONSTRUCTION	(X3) DATE SUF COMPLET	
AND PLAN O	F CORRECTION	IDENTIFICATION NOMBER.	A. BUI				
		445445	B. WI			12/01	/2011
	ROVIDER OR SUPPLIER	BILITATION CENTER		12	EET ADDRESS, CITY, STATE, ZIP CODE 0 PITCOCK LANE ELINA, TN 38551		
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F 441	2011, at 11:49 a.m gums hurt through Observation on Derevealed the reside mechanical soft, pure Interview with the the DON's office op.m., confirmed the notified and provide the resident's denth hospital prior to act the resident was undentures because family would like the new dentures. Confacility had not mare resident to receive 483.65 INFECTIONS SPREAD, LINENS The facility must be a linearly and to help prevent the of disease and information (a) Infection Control of the facility must be a linearly	resident on November 28, a., confirmed, "sometimes out the day"  Recember 1, 2011, at 1:30 p.m., ent eating a meal consisting of ureed meat food items.  Director of Nursing (DON) in an December 1, 2011, at 2:30 e resident's family had been led the following information, tures had been lost at the dmission to the nursing facility, anable to wear an old set of they didn't fit properly, and the he resident to be refitted for entinued interview confirmed the de arrangements for the ded arrangements for the entered and services.  IN CONTROL, PREVENT  Sestablish and maintain an Program designed to provide a comfortable environment and the development and transmission fection.  Tol Program establish an Infection Control hich it - controls, and prevents infections procedures, such as isolation, at to an individual resident; and ecord of incidents and corrective	F	411	<ul> <li>12/1/11 through 12/13/11 regarding proper assessment planning, and provision of services.</li> <li>4. The Director of Nursing audit fifteen dental assessments per week weeks then fifteen character of the month for two months 100% compliance is a All results will be reported monthly by the Director Nursing to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrated Director, Administrated Director of Nursing, Set Coordinator, Minimum Set Coordinator, Minimum Set Coordinator, Social Services, Activities Directory Manager, and Housekeeping Supervises</li> </ul>	f dental  ng will  for four arts per s or until chieved. orted or of ce tee ical or, taffing m Data al irector,	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	BILITATION CENTER	1	REET ADDRESS, CITY, STATE, ZIP C 120 PITCOCK LANE CELINA, TN 38551	ODE		
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F 441	(b) Preventing Spr (1) When the Infect determines that a prevent the spread isolate the resider (2) The facility mu communicable dis from direct contact will (3) The facility mu hands after each hand washing is in professional practice.  (c) Linens Personnel must hands the transport linens infection.  This REQUIREM by:  Based on observation.  This REQUIREM by:  Based on observation.  This revealed Lines in the findings included the communication of the communication	ead of Infection ction Control Program resident needs isolation to d of infection, the facility must it. st prohibit employees with a sease or infected skin lesions it with residents or their food, if transmit the disease. Ist require staff to wash their direct resident contact for which indicated by accepted tice.  andle, store, process and o as to prevent the spread of  ENT is not met as evidenced vation, review of facility and interview, the facility failed to on was administered in a sanitary #29) of twelve residents the medication administration		1. LPN #1 was inset 11/29/11 regarding medication admit policies. Resident assessed by the I Nursing on 12/1/2 adverse affects. It outcomes were in MD and family won 12/1/11 by the Nursing.  2. The Director of I began medication observations on ensure that medical administration policing followed of for all residents. residents were idhaving been affects.  3. All licensed nursing inserviced on 12/1/2 Director of Nursifollowing infection practices in medical administration.	nistration at # 29 was Director of 11 for any No adverse dentified. The vere notified be Director of  Nursing a pass 11/29/11 to cation Dicies were consistently No other entified as cted.  es were 1/2/11 by the ling regarding on control	Completion Date 12/22/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1.	ULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  CELINA HEALTH AND REHABILITATION CENTER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE 10 PITCOCK LANE ELINA, TN 38551	1	1129	
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F 441	treat/prevent ulcer Schizophrenia) and Continued observation removed a group meq (millequivale observation reveal manufacturers' late and with the bare and placed them  Review of the fact Medication Pass guideline) revised "Meds (medication on cart or floor art is performed"  Interview with the December 1, 201 office confirmed	age 9 s) and Seroquel (to treat ad mixed in applesauce. ation revealed the LPN of 4 Potassium Chloride 10 ints) capsules. Continued alled LPN #1 pulled back the bel from the plastic package fingers removed two capsules in the applesauce mixture.  ility documentation titled Evaluation (serves as facility a September 28, 2011, revealed, ans) touched by nurse, dropped in e disposed of and hand hygiene  E Director of Nursing (DON) on 1, at 3:25 p.m., in the DON's the facility failed to ensure the administered in a sanitary	F	441	4. The Director of Nursi conduct five medicative administration observed per week for one mone five observations per for two months to mo compliance or until 10 compliance is achieved results will be reported monthly to the Quality Assurance Performant Improvement Commicomprised of the Medical Director, Administrated Director, Administrated Director of Nursing, Scoordinator, Minimum Set Coordinator, Minimum Set Coordinator, Social Services, Activities Director of Dietary Manager, and Housekeeping Supervioles.	on ations ath then month nitor 00% ed. All d y ce ttee lical or, Staffing m Data al pirector,	